Can You Manage Managed Care?

Save to myBoK

by Sue Willner, RHIA

HIM professionals' data management skills make them a hot property in many settings, but none more so than managed care. In this second installment of the Journal of AHIMA's special series on managed care, the author describes the ways managed care organizations use data and how HIM professionals can contribute.

You just received an enticing offer from a nationally known managed care organization (MCO) to interview for a newly created position to "manage their data." The money is great and the location intriguing. But you have never worked in managed care, and you don't know how well your skills translate. In fact, you are not even clear what managed care is. Are you naïve to think that you can consider this job?

No, not at all. Not only are you qualified to consider this job, but in fact, you have skills, vision, and expertise that are valuable to helping MCOs achieve their goals.

In recent years, healthcare has become so complicated that the lines between managed care and the rest of the industry have blurred in unexpected and surprising ways. The mergers, buy-outs, restructuring, and integrations of the last 10 years have affected both managed and "non-managed" care so comprehensively that there are more similarities than differences in the aspects of the business regarding data and information management.

So before insecurities undermine you, consider performing an objective pre-interview assessment to determine if this is a worthwhile opportunity for you. What do you know, what don't you know, and how difficult will it be to converse knowledgeably and confidently about data, databases, and data-related needs in the managed care setting? This article will help you find out.

What Is Managed Care?

With all the recent negative publicity surrounding managed care, it is easy to forget that managed care is merely a generic term for a system or process designed to manage costs, quality, and access to healthcare services for a select population of enrolled members. The MCO could be a health maintenance organization (HMO), a preferred provider organization (PPO), a point-of-service plan (POS), or more likely a hybrid, because most of the original models have metamorphosed into a mélange of MCOs with varied characteristics. Furthermore, if the MCO is an HMO, it could be a staff, group, or network model, an independent practice association (IPA), or a mix of different models.

All MCOs, despite their diverse structures, are facing an information maelstrom. Now, more than ever, their ability to deliver information to the right place at the right time is a strategy for survival. MCOs are scrambling, not unlike their colleagues in the non-managed care world, to translate their voluminous data into accurate, complete, and timely information that serves the needs of their primary stakeholders.

An HIM professional preparing for a job in managed care must therefore understand the incentives of each of the major players and be able to answer the question "How can I, through my knowledge, experience, and vision of information management, support these stakeholders so that this organization can attain its short- and long-term goals?"

Stakeholders: Who Is Bearing the Risk?

First, it's important to understand that the concept of risk is at the heart of managed care. Historically, managing care meant that healthcare providers were "at risk" by accepting the same payment per plan member, regardless of the actual cost of

treatment. Those fixed prepaid fees, known as capitation, are the bedrock upon which managed care was based.

But like everything else in the healthcare industry today, things have gotten complicated. Capitation is disappearing as a basis for risk payments and is being replaced by more sophisticated risk-adjustment systems. Everyone involved with managed care has a stake in the competing demands of patient care and economic viability, and therefore risk is now shared by many.

For HIM professionals, this means that the various stakeholders need accurate information and efficient information systems to help them play their respective roles in balancing the goals of trying to provide quality healthcare while maintaining financial health.

HIM professionals are already familiar with the healthcare industry's four primary stakeholders: patients, providers/practitioners, payers/insurers, and the government (as regulator). But as you consider entering managed care, you must also appreciate the role of employer groups and health plans, two players who add considerable complexity to an already crowded field of data needs.

The Primary Stakeholders

Employer Groups

As a managed care novice, you may be surprised by the influence, power, and impact of employer groups. But it makes sense once you realize that employers are the largest purchasers of healthcare, with huge incentives to reduce overall healthcare costs by keeping employees healthy. In a recent article describing General Motors' internal disease management program, the authors note that "the challenge for GM and hundreds of other health plan sponsors is to invest healthcare dollars in prevention and treatment that provide return on investment (ROI)."1

Employer groups therefore apply major pressures and significant data demands on MCOs, which means much work for HIM professionals. The Health Plan Employer Data and Information Set (HEDIS), for example, provides employer groups and healthcare consumers with the data needed to compare health plan performance.

A continuously evolving set of performance measures, HEDIS requires tremendous health plan resources to collect, submit, and ensure the quality of data. You, as the MCO's health information professional, would be intimately familiar with the HEDIS set of quality, access, and cost indicators, the source databases, and the process from data collection to submission to audit.

Many large companies and employer groups require MCO accreditation to demonstrate that they deliver high-quality healthcare that is accessible and responsive to member needs. As a key member of any accreditation survey preparation team, you would ensure that your MCO's data could meet the rigorous standards set by the accrediting organizations.

The National Committee for Quality Assurance (NCQA), for example, requires an MCO to show baseline data on why a particular problem or area was chosen for quality improvement, where they started, where they are now, where they expect to go, and how they will know when they improve. Furthermore, the data must be properly sampled, presented, and interpreted to the satisfaction of sophisticated surveyors. An HIM professional specializing in data management would be a central player in using data to demonstrate quality or identify areas for quality improvement.

More recently, employer groups are again leading the way as the healthcare industry is faced with the challenge of increasing efforts to protect patient safety and reduce medical errors. The damaging 1999 Institute of Medicine (IOM) Report, with its stunning announcement of patient mortality due to medical errors, was followed by a second report in February 2001 that criticized a healthcare delivery system "plagued by a serious quality gap."2 Your contribution will likely be to help select and implement systems designed to minimize medical errors and provide members with data that demonstrate meaningful improvements in patient safety.

Health Plans and Their Members

In a recent article in Health Data Management, Ralph Korpman, president and CEO of e-health company HealthTrio, Inc., observed that health plan members, another managed care stakeholder, have two basic needs: gaining information on their own health and knowing how much money they owe to whom.3 These needs may sound simple, but the information demands of

plan members are a comprehensive challenge for data experts in any organization. Now, with the new privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA), this task becomes even more daunting.

In the volatile and threatened managed care market, where member retention is of considerable concern, health plans must increase their membership by enhancing relationships between members and providers and between members and the plan itself. To accomplish this, innovative MCOs are planning to invest in building one-on-one relationships with their members through the Internet. They want to communicate with their members about everything that a member cares about, including enrollment, benefits, referral information, health assessments, claims status reports, online prescription ordering, accreditation results, quality report cards, and preventive health.

However, HIM professionals know that patient data are often far from accurate and complete. Data and databases abound but MCOs, like the non-managed care world, still lack the ability to provide the right information at the right place and time. With so many different databases, healthcare analyst Cynthia Burghard of the Gartner Group commented recently that “you spend 50 percent to 80 percent of your time reconciling differences in data rather than actually doing something with it.”4

Furthermore, the quality of the data that are acceptable to MCOs for making business decisions is different than the quality required of personal data that will be scrutinized by members. This point is key to why MCOs need the services of skilled HIM professionals who are adept at managing data.

Inside the organization, poor data quality is a problem. But it could be downright disastrous if a member viewed her own health information online and found that her MCO had incorrect or missing data in her record.

This is where MCOs need your expertise to help design IT systems that efficiently deliver online information to their members. As their HIM professional, you know the data, you know the databases, and you understand the users’ needs; this makes you a vital consultant when it comes time to design the new generation of healthcare information delivery systems.

Health Plans and Providers

MCO physicians, like physicians in any healthcare organization, are key stakeholders who want to devote more of their time and energy to treating patients and therefore seek to reduce the time and cost of administrative tasks. Their wish list often includes less intrusion by MCOs into treatment decisions, less onerous medical record documentation, reduction of conflicting and confusing third-party payer regulations and billing rules, and more administrative support.

Recent actions on the national scene have intensified physician concerns with these same issues. The IOM’s reports identifying patient safety problems, the Office of the Inspector General’s (OIG) work plans and compliance programs, and the Healthcare Financing Administration’s (HCFA) ongoing onslaught of changing Medicare regulations and reimbursement systems will continue to increase physician concerns regarding the support they need.

Physicians look to their MCO to solve their perceived problems. They want information systems that eliminate or greatly reduce their administrative work. HIM professionals, with their expertise in data and data systems and their understanding of physicians’ needs, can provide expert consultation in designing systems of value to physicians. When it comes to order entry, the electronic patient record, integrated documentation, billing and claims systems, and other clinical support systems, you can provide crucial input and guidance to improve patient data while supporting the needs of physicians and, ultimately, of the MCO.

The Health Plan and Its Information Needs

Of all the managed care stakeholders, the health plan itself has the broadest and most diverse set of information needs, encompassing all realms of the business of healthcare. The MCO has numerous databases due to its administrative, financial, and clinical responsibilities. Many are similar to those in the non-managed care world and others are unique. Databases of enrollees, authorized outside referrals, and claims for referred services to plan members are common in MCOs, while utilization and claims data are found inside and outside managed care.

Even when the databases might be familiar to both settings, the interpretation and understanding of the data might differ. To succeed as an HIM professional in an MCO, for example, you must understand the different incentives involved in utilization management.

Unlike in the non-managed care setting, the financial incentive for MCOs is to reduce utilization of healthcare resources so that the risk payment they receive for a member exceeds the money they expend on care. But the government and employer groups who want to ensure that members are getting the health services they require and who are primary payers for that care vigilantly watch for evidence that managed care organizations (MCOs) withhold necessary and appropriate care to save money. So while the non-managed care world is constantly audited for overutilization of healthcare services, MCOs are under scrutiny for underutilization.

The HIM professional's role in this MCO challenge is to optimize accurate, complete, and timely data at the points of care so that correct utilization decisions can be made at the appropriate times in the appropriate places. While MCOs require data that reflects the full range of health services provided to avoid the suspicion of limiting care to protect profits, they also require quality utilization data for numerous other reasons, including forecasting rates and premiums, identification of medical outcomes and best clinical practices, analysis of provider practice patterns, and of course, accurate third-party reimbursement.

In recent years, MCOs have recognized that they need to keep members healthy so that they don't require expensive health services. The turnaround has resulted in a renewed appreciation of maintaining members' health through preventive screenings and services and recognizing the importance of managing member illnesses now instead of responding with more expensive treatment later.

To accomplish this, MCOs must identify their high-risk and high-cost member populations, initiate and record actions, and track outcomes. From the need for these activities have grown entirely new clinical and administrative functions—e.g, case management, care management, disease management—all of which have significant data and systems needs. Very recently, predictive modeling, which uses a self-evaluation survey of non-disease-based factors to predict those individuals at risk for developing serious health problems, is drawing the attention of MCOs investigating innovative ways to increase quality of care and decrease costs.

At the same time, HCFA and the federal Agency for Healthcare Research and Quality are researching ways to better align payment methods with quality improvement goals. In the next years, MCOs will receive financial incentives to demonstrate compliance with HCFA's specific clinical guidelines. Beginning with treatment of congestive heart failure, payment for healthcare services will be tied to quality of patient care as defined by predefined clinical criteria. MCOs will therefore have additional motivations to collect and submit complete and accurate clinical and administrative data. The success of all these efforts will depend on new data, databases, and user-friendly data systems, which of course will require the expertise of HIM professionals.

Reimbursement Mechanisms: What You Should Know

When it comes to reimbursement, the good news is that the HIM professional's knowledge of HCFA's prospective payment systems (DRGs, APCs, RUGs, new PPS for inpatient rehabilitation and home health care) and the coding systems upon which they are based (ICD-9-CM, HCPCS, CPT) will be as vitally important in managed care as in your current job. Furthermore, familiarity with OASIS for home health, the Minimum Data Set for long term care, and any of the upcoming prospective payment systems will be applicable in this new world as well.

However, you also have some learning to do to understand the complexities of billing in managed care. While you are probably all too familiar with the confusing mix of funding mechanisms used in today's healthcare delivery system, billing and payment in the managed care world is even more complicated.

Issues like health plan members versus non-members, types and nature of coverage, capitation versus cost-based payments, out-of-network versus in-plan, out-of-area versus in-area, negotiated contracts or fee-for-service, and more, must be considered in addition to those we know from the non-managed care world.

In addition, HCFA is currently implementing an entirely new payment program for Medicare beneficiaries who choose managed care. The reimbursement mechanism for these Medicare+Choice beneficiaries is a risk adjustment classification system that requires MCOs to provide diagnosis and service data for virtually all patient encounters. The system bases payments for healthcare services on the identification of certain chronic conditions that predict subsequent healthcare service costs. Collection, aggregation, and external submission of this comprehensive data set is relatively new to the managed care industry and presents serious challenges to most MCOs.

To be phased in within the next three years, this payment mechanism is having a significant impact on MCOs from a data and cost perspective. The databases and systems that MCOs must design and maintain in order to submit full UB 92 and HCFA 1500 data sets for Medicare reimbursement of all members for all care provided across the continuum are extensive and expensive and require comprehensive data management skills.

As an HIM professional for an MCO, you will have to understand this new payment system and appreciate the difference in the data requirements and incentives. While the correct principal diagnosis and complication and comorbidities (CCs) are crucial to DRGs and the accurate coding of procedures and services is key to APCs, the coding of chronic conditions is now of utmost importance to the managed care world. Your knowledge of coding and reimbursement systems, understanding of the basic principles of data quality management, including the importance of standardized data definitions, and experience with minimizing organizational risk by compliance with regulatory requirements will be important to your MCO.

Furthermore, bearing in mind the four key functions serving as the basis for an HIM process in a MCO—data process and records management, informatics, decision support/analytics, and quality improvement—can help to understand the big picture. (See part one of this series, “How HIM Adds Value to Managed Care,” in the June 2001 issue.)

Looking Ahead

The last few years have been especially difficult for managed care. The hope that it would magically ensure accessible and affordable quality healthcare for all Americans has faded. MCOs face serious challenges and barriers.

A recent report by the President’s Information Technology Advisory Committee criticized the healthcare industry for not using information technology as a strategic resource to improve access to care, to more effectively prevent medical errors, and to accelerate medical research. It blames the industry for not having vital information because its data is spread across multiple information systems and organizations with differing systems.[5] The reluctance of industry leaders to invest in information technology to standardize data and systems has placed healthcare behind every other American industry in its use of new technologies. Recognizing the same problem, the IOM has proposed a $1 million innovation fund to upgrade healthcare delivery systems in the US.

So, as always, data is everywhere, but usable information is disturbingly limited due to its lack of standardization, integration, and interconnectivity. Despite the preponderance of data and databases, MCOs either do not have the information necessary to impact decisions or “have not yet learned how to effectively use information to change or make decisions.”[6] The initial excitement over the potential of data warehousing to provide standardized data to the desktop for easy manipulation into information has waned as the reality of the resources and commitments required set in. The industry has been exceptionally slow to embrace standardized data definitions and formats and in fact is only beginning to do so as HIPAA implementation looms on the horizon.

You, as the HIM professional, can help the organization manage the conflicting data priorities of its stakeholders and help integrate and connect data and systems with each other and with its audiences. You have the skills, experience, and vision, and with managed care, you have the arena. This is a challenging and exciting time for HIM professionals to contribute all you know to a multidisciplinary effort to make a difference to the many layered challenges and opportunities in healthcare. Don’t let the organizational structure fool you; you have much to give to managed care. And they will succeed with your help.

Keep Up to Date on Managed Care

The Journal of AHIMA is publishing a series of articles on managed care and HIM professionals. The first installment, “How HIM Adds Value to Managed Care,” appeared in the June 2001 issue. Look for more on managed care in upcoming issues of the Journal.

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